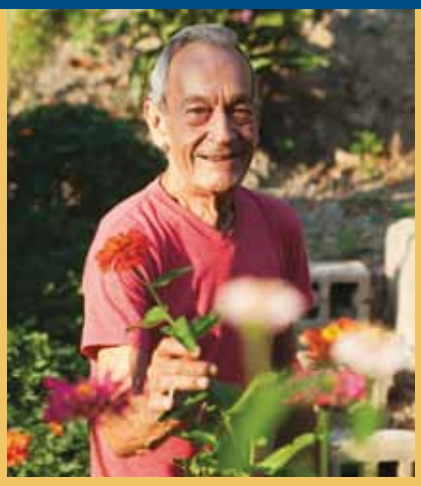
2012 Annual Report


Bristol-Myers Squibb Foundation

Together ON Diabetes

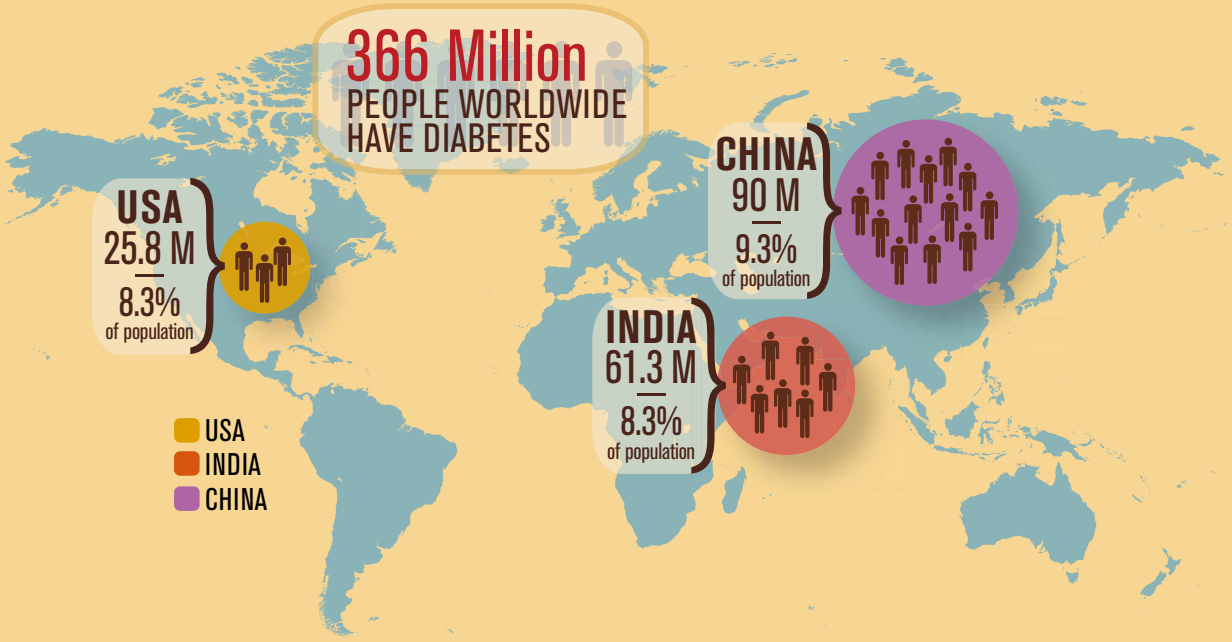
Communities Uniting to Meet the Challenge of Diabetes
in China, India and the United States





Bristol-Myers Squibb Foundation

DIABETES BY THE NUMBERS



***Together on Diabetes*™ is now working in the three countries that have the most people living with type 2 diabetes: China, India and the United States.**

Statistic sources: *U.S. Centers for Disease Control and Prevention; International Diabetes Federation Diabetes Atlas*

A MESSAGE FROM THE PRESIDENT

The second year of the *Together on Diabetes*™ initiative saw great progress by our grantees in their projects across the United States, the creation of a number of exciting new partnerships and expansion of the initiative to China and India.

In 2010, when we announced our five-year, $100 million commitment to fund programs in the United States that address health disparities in type 2 diabetes, *Together on Diabetes* became the largest corporate philanthropic commitment of its kind. In May 2012, the Foundation committed an additional $15 million over five years to fund programs in China and India to help catalyze the response to diabetes at the patient and community levels.

With this expansion, *Together on Diabetes* is now working in the three countries that have the most people living with diabetes worldwide: China is first with 90 million, followed by India with 61.3 million and the U.S. with 25.8 million. Within these populations, *Together on Diabetes* is carrying out the Foundation's mission as a champion of health equity by focusing on those populations bearing the greatest burden of disease – the poor, elderly, racial and ethnic minorities, as well as those living in areas that have limited access to health information and services or resources supportive of healthy eating and active living.

This second annual report provides an update on the initiative's grantmaking and profiles how the grants are helping people living with diabetes to take control and improve control of their disease. It also illustrates how they are helping communities to come together to make diabetes information and supportive services more visible, accessible, navigable, culturally competent and integrated with clinical care. The report also captures initial results and early lessons from the projects.

To date, the U.S. initiative has committed $43.2 million in funding for 21 grants with projects working in 28 states and more than 50 communities. Over the past year, *Together on Diabetes* has created new partnerships that are focusing on Native American families at high risk for diabetes, increasing the uptake of diabetes self-management programs among seniors and re-engaging patients who have fallen out of care. *Together on Diabetes* has also forged partnerships with experts to evaluate the progress and impact of the initiative and to help the Foundation and its grantees to effectively mobilize the results and lessons learned from the projects into policy and advocacy efforts at the local, state and national levels.

We are enormously proud of the work of our *Together on Diabetes* grantees and partners. They are engendering hope among those hardest hit by the diabetes epidemic and transforming communities so that the healthy choice is an easier choice for people living with type 2 diabetes.

John Damonti
President, Bristol-Myers Squibb Foundation
Vice President, Corporate Philanthropy, Bristol-Myers Squibb

PATIENTS TRANSFORMING LIVES TOGETHER

Making an IMPACT on Type 2 Diabetes

When it comes to helping patients who are suffering from a chronic disease such as diabetes, pharmacists are in a good position to make a positive impact. Just ask Awa Kare.

When the 57-year-old native of Senegal was diagnosed with type 2 diabetes in August 2011, she not only had to contend with the health issues associated with diabetes but also faced cultural challenges, including how to continue eating foods in the native diet that she loved and her lack of knowledge of English.

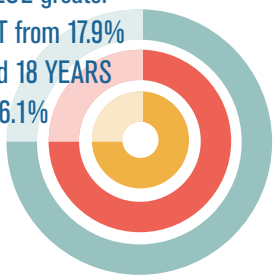
Kare`s HbA1c level, a measure of glucose in the blood, was higher than 14 percent. An HbA1c of greater than 6.5 percent is the threshold for a diabetes diagnosis. While Kare understood the medical challenge facing her, coming from a society in which older women are dependent on others for many things, she needed to learn how to help herself.

She found the support she needed in Terry Lawson, a pharmacist at Zufall Health Center in Dover, New Jersey. Zufall is part of *Project IMPACT: Diabetes*, a program run by the **American Pharmacists Association Foundation** and funded by a $4.3 million, four-year grant from the Bristol-Myers Squibb Foundation. *Project IMPACT: Diabetes* is integrating pharmacists into the care model of teams serving 25 high-need, primarily Medicaid-insured communities across the U.S.

Lawson asked family members to assist with translation and set about educating Kare about diabetes and how it was affecting her body. She taught her how to monitor her glucose level and counseled her about the medications she was prescribed. She also explained the benefits of exercise,

U.S. Healthy People 2020 Diabetes Objective D-5.1

REDUCE the PROPORTION of the DIABETIC POPULATION with an A1C VALUE greater than 9 PERCENT from 17.9% for ADULTS aged 18 YEARS and OLDER to 16.1%



A diabetes diagnosis can come as a shock — even for a person in a family already heavily affected by the disease. Important steps toward coping with and controlling diabetes over the long term are accepting that diabetes is a chronic disease that will always be part of their life and understanding that it is a part of their life that they *can* do something about. They do not, however, need to do it alone. With access to diabetes self-management education, healthy eating and active living resources, and social support, people living with diabetes can play an active and effective role in their own care.

The innovative programs of the *Together on Diabetes* grantees are showing how to make these transformations possible for highly affected populations and along the way also seeing that the changes people living with diabetes are making to control their disease are accruing benefits to their overall well-being.

LESSON 1: TRY AND ERR, THEN PRACTICE, PRACTICE, PRACTICE

Whether you are learning a new language or how to play a musical instrument, the more you practice, the better you become. The same is true for people living with type 2 diabetes. Effective self-management takes periods of trial and error to learn what works and then practice to gain competency in doing them.

With a $300,000, two-year grant from the Foundation, **United Neighborhood Health Services** in Nashville, Tennessee, is encouraging African American women living with type 2 diabetes to make physical activity a regular part of their lives. The program incorporates a fitness expert into the clinical team. The fitness expert works with patients to create personal plans to move more each day. At six months, 89 women are enrolled and a quarter of them have lowered their HbA1c levels.

proper nutrition and using community resources.

Lawson met with Kare at each monthly visit to the clinic and, with Lawson`s encouragement, Kare began taking daily walks. Since her daughter and son-in-law both work, she went alone, something she had never done before. In Senegal, she always was accompanied by someone else.

Kare also began cooking her own healthy meals. She would monitor her blood sugar level with a glucose meter throughout the day and take her medicine as prescribed. "Awa has successfully implemented all of the pieces of self-management," Lawson says. "She initially thought she would have to give up all the foods she loved from her culture and was very happy to learn that she could eat healthy within her culture as long as she watched the portions and the balance of food on her plate."

At a recent monthly checkup, Kare's HbA1c level was 5.9 percent and she had lost weight. "I'm very proud of myself and the changes I've been able to make in my health and in my life," she said through her daughter, Soukenya. "I feel like I have my own power now. I am able to do things for myself and I feel great!"

***Project IMPACT: Diabetes* is engaging pharmacists like Lawson as essential participants in team-based, patient-centered care delivery. They can assist people living with diabetes to successfully and knowledgeably implement their self-management plan and also to access the medical standard of care such as foot and eye exams. To date, 81 pharmacists have been trained, over 1,900 patients have enrolled in the program and six month clinical evaluations show an average HbA1c of 8.5 percent – down from the average of 9.5 percent at baseline.**

LESSON 2: MEET PEOPLE LIVING WITH DIABETES WHERE THEY ARE IN THEIR LIVES

Diabetes programs can be successful when they connect to people where they are in their lives – geographically, culturally, emotionally and socially – and not just where they are in their disease journey. Foundation grant recipients **Whittier Street Health Center** and the **Black Women's Health Imperative** are each using their $300,000, two-year grants to engage African American women living with diabetes.

Whittier Street is taking its linkage-to-care and diabetes education efforts "to the people" in a public housing development in Roxbury, Massachusetts, with the help of community health workers. In three wards in Washington, D.C., the Imperative is implementing the Health Wise Woman Diabetes Management project in partnership with churches and community-based organizations like N Street Village, a women's shelter.

At six months, Whittier Street Health Center has screened 409 African American women for type 2 diabetes, enrolled 123 in its program and improved access to diabetes standard of care and HbA1c levels. The Imperative has trained 27 women to facilitate Sister Circle sessions and enrolled 65 women in its program.

LESSON 3: PEER TO PEER SUPPORT UNIQUELY STRENGTHENS SELF-MANAGEMENT

People living with diabetes can be a unique support to each other. Since they walk in the same shoes, they understand each others' challenges. When they succeed in controlling their diabetes, they can offer hope as well practical advice to their peers.

Small Changes Are Big Steps Toward a Healthier Life

Margaret Askew was well aware of the devastating effects of type 2 diabetes. Her father suffered from the disease most of his life and had both legs amputated because of complications. Shortly after he lost his second leg, Askew learned that she had type 2 diabetes.

"When you see what can happen to someone who has the disease and then find out you have it, it's really scary," she says.

Askew got serious about making changes to her life in order to avoid complications like her father's. Thanks to a program run through **East Carolina University's Health Disparities Center** and a $300,000, two-year grant from the Foundation, she didn't have to do it alone.

Askew is one of 144 African American women with type 2 diabetes who live in rural North Carolina currently enrolled in a program that connects them to a community-based team of lay health workers who help them self-manage

The American Academy of Family Physicians Foundation's Peers for Progress initiative is using its $5.2 million, three-year grant to incorporate *Compañeros en Salud* into patient-centered medical homes to provide disease management support. *Compañeros en Salud* are Hispanic health promoters from the same community as the patients they serve. They help the patients to put their self-management plans into action. Since the August launch at Alivio Health Center in Chicago, Illinois, 9 promotoras *Compañeros* have been trained and 238 patients have been enrolled.

Call to Health, a pilot project of the **University of Virginia** funded with a $300,000, two-year grant from the Foundation, uses text messaging to reinforce healthy behaviors among African American women living with type 2 diabetes. At six months, 43 women are enrolled and receiving text messages as well as participating in group education.

LESSON 4: INTEGRATE DIABETES AND DEPRESSION SELF-MANAGEMENT PROGRAMS

A patient living with type 2 diabetes often lives with other chronic conditions like depression, which is the most common comorbidity, and these should be addressed together.

Riverview Medical Center Foundation in Neptune, New Jersey, received a $50,856 grant to pilot an innovative approach for patients to develop a personalized action plan that increases diabetes selfcare and wellness in six areas: physical, emotional, social, vocational/educational, spiritual and intellectual. Four educators have been trained to deliver the program and recruitment activities are underway.

> "When people embrace their diabetes rather than being at war with it, when they make it part of their lives, I think they're more likely to take their medications, monitor their blood sugar, eat mindfully and engage in physical activity."
>
> **–Dr. John Buse, MD**
> Director, University of North Carolina Diabetes Center
> Member, *Together on Diabetes* U.S. Expert Advisory Council

their disease. The program, called *Small Changes,* pairs patients with a health ambassador and a health navigator — who are also African American women from their community — and emphasizes making incremental changes in diet, physical activity and self-care choices.

Through the team's guidance and her own desire to change the course of her diabetes, Askew made a series of small but sustainable behavior changes that are having a big impact on her health. She attends monthly diabetes group meetings, began a walking routine and modified her diet.

"I love sweet tea and was drinking about 10 cups a day," she says. "My health ambassador suggested I try to give up just one at a time, and now I drink no more than one a day." Since beginning the *Small Changes* program, Askew has lost 69 pounds and her HbA1c level dropped from 8.3 percent to 7.2 percent.

The health ambassador leads the support group sessions and provides the participants with one-on-one coaching, guiding them through a 16-week-self-management curriculum. The navigator helps the participants to access medical and non-medical resources to manage their disease. Both the ambassador and navigator serve as important extensions of the clinic-based primary care team.

Askew has undoubtedly taken a big step toward living healthier by making small changes. "I feel 100 percent better, I look better and I have more energy," she says. "It's hard to put a value on what this has done for my life. I am a better person because of it."

TYPE 2 DIABETES IS MORE COMMON AMONG AFRICAN AMERICANS, LATINOS, NATIVE AMERICANS AND ASIAN AMERICANS, NATIVE HAWAIIANS AND OTHER PACIFIC ISLANDERS THAN AMONG NON-HISPANIC WHITES.

COMMUNITIES UNITING TO ADDRESS DIABETES

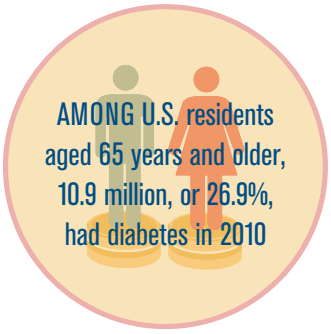
Diabetes Classes for Seniors Come to the Neighborhood

Riverstone Senior Life Center in the Washington Heights/Inwood section of New York City is a bustle of activity on most days, but especially Thursdays. This is when about 50 senior citizens from this heavily Dominican neighborhood gather on Diabetes Day for individual counseling and group education all geared toward helping them self-manage their type 2 diabetes.

The program at Riverstone is one of five in Washington Heights that are coordinated by United Hospital Fund and funded by a three-year, $2,845,967 grant from the Foundation.

In New York City, almost 25 percent of people age 60 and older are diagnosed with type 2 diabetes. In naturally occurring retirement communities, areas in which a significant number of elderly reside, prevalence can be even higher. Washington Heights is one such community. Of its total population of 250,000, 41,000 are senior citizens. Their rate of diabetes is 26 percent, the second highest in New York City.

United Hospital Fund is partnering on its *Together on Diabetes* project with the New York City Department of Aging and the New York City Department of Health and Mental Hygiene. The goal is to establish community-based care for seniors with diabetes that integrates clinical care with diabetes education, social services and community support.



For years, the medical community has responded to patients diagnosed with type 2 diabetes by providing appropriate clinical care, treatment and self-monitoring tools to help them track their blood sugar levels. But the daily challenge of managing diabetes goes well beyond medical interventions. Patients often need to make lifestyle changes as well. For many, making even simple changes can be a challenge.

Part of the solution lies in encouraging people affected by diabetes to take action and to help develop, own and advocate for the solutions they want to see implemented in the settings where they live, work, play and pray. *Together on Diabetes* grantees are making inroads with projects that seek to mobilize and transform communities. Important lessons are being learned along the way.

LESSON 1: ZIP CODE: KNOW WHO IS AFFECTED BY DIABETES AND WHERE THEY LIVE

Change begins when people start to think differently. In the case of diabetes, that could involve a shift in the way the diabetes burden is measured and described. With a $6.25 million grant from the Foundation, **Duke University Medical Center**, in partnership with the Durham (North Carolina) County Health Department and the University of Michigan, is trying to do just that through a new concept: geospatial mapping of the diabetes burden.

This approach reveals where a concentration of people with diabetes are living and allows community engagement and intervention efforts to be targeted to those neighborhoods. Duke and its community partners are now developing and implementing a comprehensive diabetes response that spans public health, clinical services, patient self-management education, healthy eating/active living supports and community organizing to meet the needs of people affected by diabetes.

LESSON 2: SYNCHRONIZE TRANSFORMATIONS IN CARE AT THE PATIENT, PRACTICE AND COMMUNITY LEVELS

Patients who live in areas where diabetes education is neither well-publicized nor accessible may not know where to start when it comes to self-managing their disease, and that can leave them feeling isolated in their diagnosis. Primary care practices can look beyond the clinic walls and refer patients to self-management programs in churches and community centers and collaborate with community partners to track the uptake and impact of education and supportive services on health outcomes.

Two grantees, the **Camden (New Jersey) Coalition of Healthcare Providers** and the **Mississippi Public Health Institute** in partnership with the Mississippi Department of Health and University of Mississippi, are changing that by strengthening efforts to integrate medical and non-medical systems of care.

In Camden, where the prevalence of diabetes is nearly 50 percent higher than the state average, the Foundation is funding a $3 million, five-year coordinated effort to improve diabetes care at the patient, practice and community levels. The Coalition has embedded practice transformation teams and diabetes nurse care managers in two large primary care practices, advertised and located self-management classes in Spanish and English in community centers and started recruiting, training and mobilizing community leaders to advocate for needed resources for diabetes management outside the clinic. At six months, 122 patients have been recruited into the program and are receiving comprehensive services.

The Mississippi Public Health Institute is using its $484,000, 14-month planning grant to develop an evidence-based community approach to lowering the incidence and severity of

Thus far, 196 seniors are enrolled in the program among the five sites in Washington Heights, which, in addition to Riverstone, include ARC XVI Ft. Washington Senior Center, Center for Adults Living Well @ the Y, Institute for Older Adults at Isabella Geriatric Center and Isabella Senior Resource Center/El Corazon NORC. Rosa Rosen (pictured here teaching), a passionate diabetes educator who is also a type 2 diabetic and a Washington Heights resident for 25 years, delivers the Diabetes Day program in Spanish at the five sites. She effectively combines her commitment to her community, her extensive knowledge of diabetes, and shared language and cultural heritage to improve the health of seniors.

"There are a lot of misconceptions about diabetes, especially in underserved communities and among people who do not have access to diabetes education programs," says Rosen.

Feedback from seniors who have participated in the program at Riverstone since May is overwhelmingly positive. Leida Delgado, 65, was diagnosed with type 2 diabetes in 2002. She attended other diabetes-focused seminars in the past but credits *Together on Diabetes* with changing her attitude about the disease. "There was no order to how I was caring for myself. Since I began attending the classes, I've learned about the benefits of organizing my meals, getting exercise and paying attention to when I need to take my medication," she says. "I have diabetes and I know how important it is for me to stay healthy."

Drawing on the Strengths of Appalachian People and Communities to Fight Diabetes

The Appalachian Region is known for the rustic beauty of its mountains and old-growth forests. It is also known for its small towns and a rich culture of resiliency and deep running familial and community ties that have helped its people to persevere through difficult times. One of the region's current challenges is type 2 diabetes. The prevalence rate in the region's poorest counties is 13.1 percent.

For the past 12 years, **Marshall University's Center for Rural Health** has partnered with the Appalachian Regional Commission and the U.S. Centers for Disease Control and Prevention to develop diabetes coalitions in economically distressed counties in the region. A $2.61 million, five-year grant from the Foundation is helping intensify the work of 10 of these coalitions.

Two of the evidence-based programs that the coalitions are implementing are *Dining with Diabetes* and *Walk with Ease*. *Dining with Diabetes* is a series of six classes that helps individuals learn strategies to manage their diabetes such as menu planning, carbohydrate counting, portion control, label reading and taste testing healthy recipes. *Walk with Ease* is a six-week exercise program developed by the Arthritis Foundation that provides participants with the information and tools they need to develop safe exercise routines that fits their individual needs and goals.

After seeing a notice for the *Dining with Diabetes* program in the newspaper, Doyle Vanmeter, a type 2 diabetic, decided to participate in the *Dining with Diabetes* program offered in Williamson, West Virginia, this past spring. His wife also attended a number of the classes with him because she prepares the family's meals. "The class helped me be more careful about what I put on my plate," he says. "I eat considerably more fish than I used to — baked or sautéed, *not fried*." The program was offered in the kitchen of a public housing apartment building, which made it easy for residents and other community members to attend. The apartment building is also located directly across the street from the community garden that has beds of vegetables and herbs. It too was started this year by the coalition.

When Alice Hope got the surprising news that she was prediabetic, her doctor suggested that she lose weight and not only begin an exercise regimen, but *lead* a six-week *Walking with Ease* program. It didn't take long for Hope to assemble a group of friends and neighbors who began walking together three days a week at a local park. Before each walk, the group would meet at a nearby church to stretch, review nutritional information and chart their progress. After six weeks, Hope had lost weight and improved her HbA1c, cholesterol and triglyceride levels.

"You can't avoid making changes that will have long-term benefits on your health," Hope says. "There are things we all want to do in our lives and something like this makes it possible to do them."

The coalitions are leveraging social networks and broadly engaging Appalachian people in efforts to reduce the impact of diabetes on their family, friends and neighbors in five counties thus far. The coalitions selected for funding in 2012 are in Lawrence County, Kentucky; Adams/Brown Counties, Ohio; Mingo, West Virginia; Graham County, North Carolina, and Meigs County, Tennessee.

diabetes among those insured by Medicaid in the Delta. Clinical, education and healthy living assets for diabetes in the region have been mapped and focus groups have been held with community leaders, patients, providers and policymakers to capture their perspectives and priorities. Key findings are that there is a gap between community members' perceived and true risk of diabetes, that there were fewer barriers to accessing a doctor than accessing diabetes education, and that there is a lack of local and state policies to promote healthy lifestyles and to prevent and control diabetes.

LESSON 3: JOIN FORCES WHEN SERVING THE SAME VULNERABLE POPULATIONS

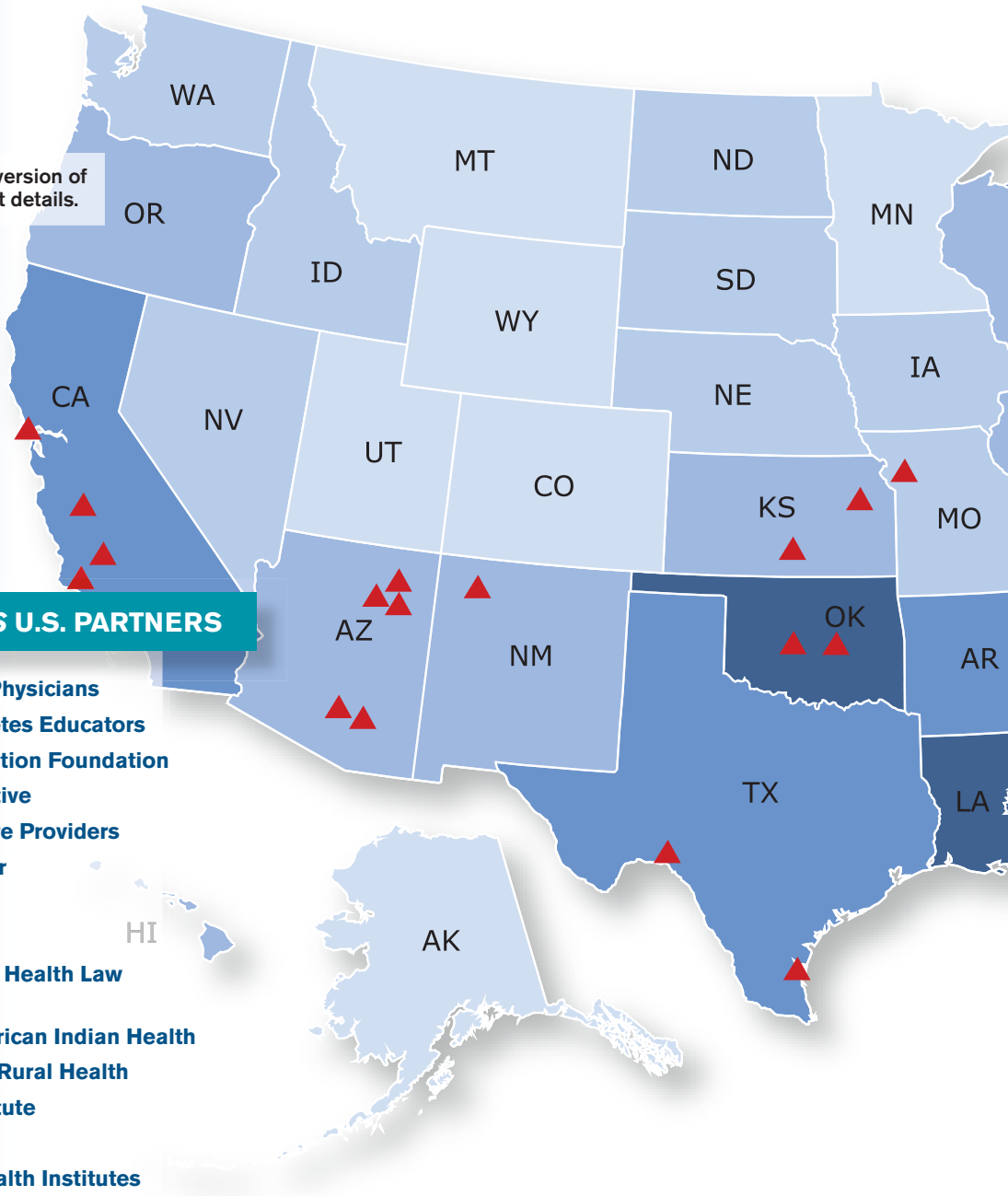
To improve health equity and address the needs of heavily burdened populations, clinics and community organizations that serve the same vulnerable populations are finding that they can have a greater impact when they join forces.

People struggling against hunger are twice as likely to develop type 2 diabetes than those who have access to healthy foods. Through a $3.1 million, three-year grant from the Foundation, **Feeding America** has created bi-directional partnerships between 25 food pantries in Texas, Ohio and California and 14 health care providers. The food banks are screening patients for diabetes and connecting them to health homes. For their part, the primary care practices are connecting patients who are diabetic and food-insecure to the food banks for nutritional education and diabetes-friendly foods. In the first year of the project, the pantries have started offering diabetes and nutrition education and enrolled 515 people in the diabetes food box programs.

> "There are people in communities who believe and know they have a right to environments that promote health and wellness. These are often the ones taking a stand. Many of our national movements were created by people taking a stand and were led by engaged communities."
>
> **–Mildred Thompson, BS, MSW**
> Director, Center for Health and Place, PolicyLink
> Member, *Together on Diabetes* U.S. Expert Advisory Council

OUR PARTNERS AND PROGRAMS

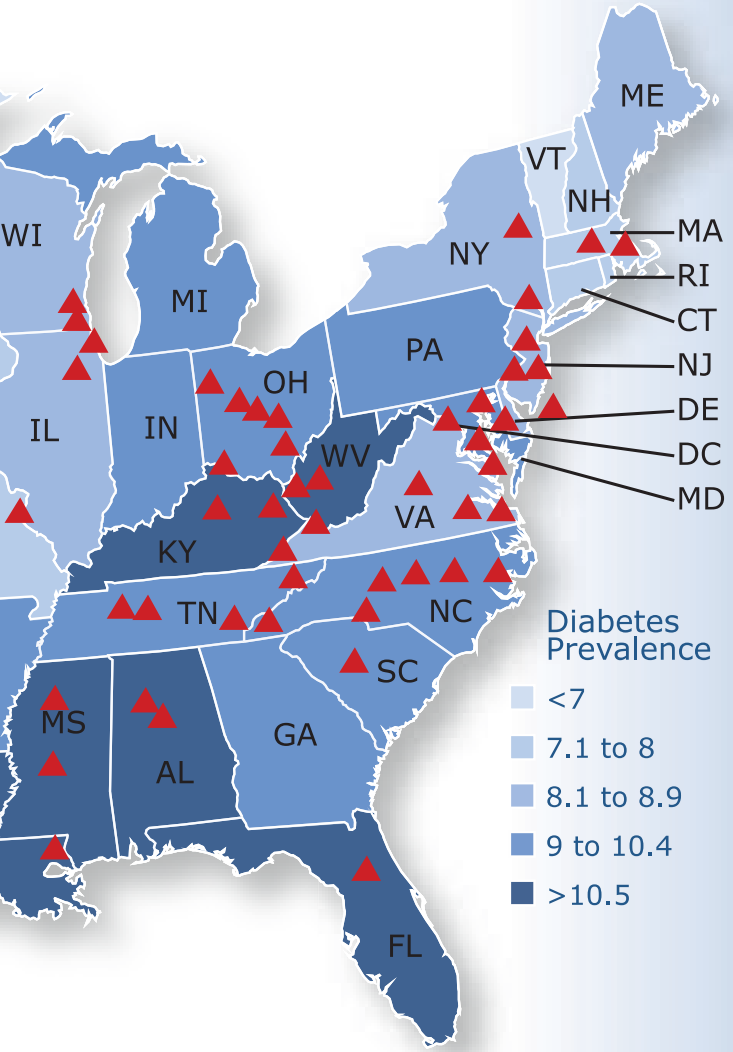
Click here to access an interactive version of this map for specific site and project details.



TOGETHER ON DIABETES U.S. PARTNERS

- American Academy of Family Physicians
- American Association of Diabetes Educators
- American Pharmacists Association Foundation
- Black Women's Health Imperative
- Camden Coalition of Healthcare Providers
- Duke University Medical Center
- East Carolina University
- Feeding America
- Harvard Law School Center for Health Law and Policy Innovation
- Johns Hopkins Center for American Indian Health
- Marshall University Center for Rural Health
- Mississippi Public Health Institute
- National Council on Aging
- National Network of Public Health Institutes
- Riverview Medical Center
- Sixteenth Street Community Health Center
- United Hospital Fund
- United Neighborhood Health Services
- University of Kansas Work Group for Community Health and Development
- University of Virginia
- Whittier Street Health Center

Prevalence map source: *U.S. Centers for Disease Control and Prevention*

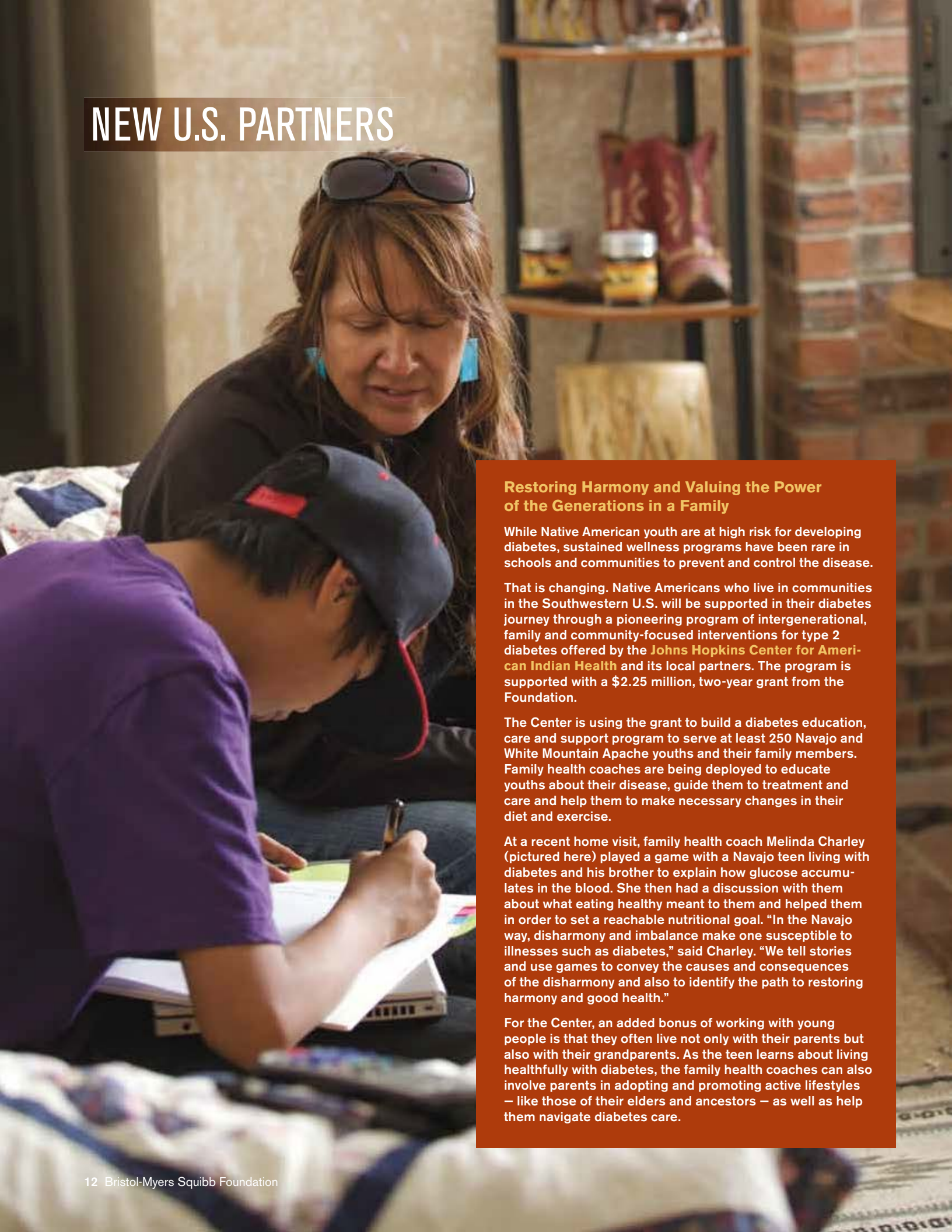


Focus on Hispanic Communities

According to the U.S. Centers for Disease Control and Prevention, 11.8 percent of Hispanics are diagnosed with type 2 diabetes, compared to the U.S. national rate of 8.3 percent. Lifetime risk estimates for developing diabetes are higher for both Hispanic men and women than for other ethnic groups. Diabetes is the fifth-leading cause of death among Hispanics in the U.S., and is a leading cause of heart disease, stroke, kidney disease, blindness and amputations.

For the past two years, *Together on Diabetes* has been supporting projects to develop comprehensive and effective solutions that leverage the strengths of Hispanic communities and health traditions such as *promotoras de salud* to improve health outcomes and reduce the burden of diabetes in more than a dozen U.S. communities with significant Hispanic populations.

NEW U.S. PARTNERS



Restoring Harmony and Valuing the Power of the Generations in a Family

While Native American youth are at high risk for developing diabetes, sustained wellness programs have been rare in schools and communities to prevent and control the disease.

That is changing. Native Americans who live in communities in the Southwestern U.S. will be supported in their diabetes journey through a pioneering program of intergenerational, family and community-focused interventions for type 2 diabetes offered by the **Johns Hopkins Center for American Indian Health** and its local partners. The program is supported with a $2.25 million, two-year grant from the Foundation.

The Center is using the grant to build a diabetes education, care and support program to serve at least 250 Navajo and White Mountain Apache youths and their family members. Family health coaches are being deployed to educate youths about their disease, guide them to treatment and care and help them to make necessary changes in their diet and exercise.

At a recent home visit, family health coach Melinda Charley (pictured here) played a game with a Navajo teen living with diabetes and his brother to explain how glucose accumulates in the blood. She then had a discussion with them about what eating healthy meant to them and helped them in order to set a reachable nutritional goal. “In the Navajo way, disharmony and imbalance make one susceptible to illnesses such as diabetes,” said Charley. “We tell stories and use games to convey the causes and consequences of the disharmony and also to identify the path to restoring harmony and good health.”

For the Center, an added bonus of working with young people is that they often live not only with their parents but also with their grandparents. As the teen learns about living healthfully with diabetes, the family health coaches can also involve parents in adopting and promoting active lifestyles — like those of their elders and ancestors — as well as help them navigate diabetes care.

NEW U.S. PARTNERS AND PROJECTS IN BRIEF

Several new partners were selected in 2012 to join *Together on Diabetes*. They are the National Council on Aging, the University of Kansas Work Group for Community Health and Development, Milwaukee's Sixteenth Street Community Health Center, the Johns Hopkins Center for American Indian Health (see article, page 12) and the Harvard Law School Center for Health Law and Policy Innovation (see article, page 13). In addition, the Bristol-Myers Squibb Foundation renewed a grant to the National Network of Public Health Institutes.

NATIONAL COUNCIL ON AGING

The National Council on Aging and its partners received a grant of $4.87 million to develop and implement a nationally scalable model for delivering the evidence-based Stanford Diabetes Self-Management Program (DSMP). While DSMP is already reimbursed by Medicare, it is underutilized due to lack of benefit awareness, physician referrals, delivery capacity and patient access – especially among disparity populations. The Council will deliver DSMP in person through community-based organizations such as YMCA USA and OASIS as well as via the internet. Stanford will provide training and technical assistance for program delivery. WellPoint, one of the largest U.S. health insurers, will promote the in-person and online workshops to members and physicians as well as partner on the evaluation design and data analysis, ensuring the implementation and results of the evaluation have real-world relevance to WellPoint and other health plans.

NATIONAL NETWORK OF PUBLIC HEALTH INSTITUTES

The National Network of Public Health Institutes received a grant of $180,144 to continue to support the *Together on Diabetes* learning community and annual grantee summit. These activities facilitate the exchange of ideas and best practices among grantees and the broader public health practice community, including the Network's 36 member health institutes and Public Health Leadership Society.

SIXTEENTH STREET COMMUNITY HEALTH CENTER

The prevalence and burden of diabetes among Hispanics exceeds that of white patients both nationally and in the largely Hispanic population served by Sixteenth Street Community Health Center in Milwaukee, Wisconsin. Sixteenth Street received a grant of $295,615 to assist Hispanic adults who are living with type 2 diabetes and who have fallen out of a doctor's care to reconnect to care through an innovative use of their diabetes registry. The project will draw heavily on linkage-to-care models used successfully for people living with HIV/AIDS.

UNIVERSITY OF KANSAS

The Work Group for Community Health and Development at the University of Kansas received a $2,885,944 grant to develop and implement an online documentation and support system to provide the Foundation and its *Together on Diabetes* grantees with real-time information about how projects are progressing toward their goals and objectives. The Work Group also will periodically meet with grantees and leaders of the *Together on Diabetes* initiative to reflect on the progress being made, identify and consider changes occurring in the community, and determine what impact the changes may have on the project and what can be adjusted and improved.

Harvard Center Leading Diabetes Stakeholders and Policymakers on the PATHS to Success

The need has never been greater for people affected by diabetes and health disparities and those engaged in the response to the epidemic to come together and effectively advocate for changes in policy and health resource allocation.

Harvard Law School's Center for Health Law and Policy Innovation is answering that call with Providing Access to Healthy Solutions (PATHS), a project designed to inform and help evolve diabetes-and health equity-related health policy at the state and national levels.

Through a four-year, $980,000 grant from the Foundation, PATHS will help *Together on Diabetes* grantees initially in Mississippi, New Jersey and North Carolina to develop a comprehensive policy roadmap for diabetes a broader information- and network-building that will underpin effort with *Together on Diabetes* grantees across the country.

"It is our hope that the core group of *Together on Diabetes*-funded entities in each state will become a strong and active part of the leadership team in each state, reaching out, becoming engaged and taking ownership of the implementation of the PATHS recommendations," says Robert Greenwald, director of the Harvard center. "These are three very diverse states, but our hope is that common themes will emerge that can be applied on a national level."

PATHS brings together diverse stakeholders and consults with them to identify successes, challenges and opportunities to strategically improve diabetes health outcomes. That information will be combined with independent research to create a framework for ongoing advocacy efforts.

EXPANSION TO CHINA AND INDIA

In May 2012, the Bristol-Myers Squibb Foundation announced the expansion of its *Together on Diabetes* initiative to China and India, pledging an additional $15 million over five years to help the growing number of type 2 diabetes patients in these developing nations better manage their disease.

The International Diabetes Foundation reports that more than 90 million people in China — 9.3 percent of the population — had type 2 diabetes in 2011, the most of any country. That figure is projected to grow to 129.7 million, or 12.1 percent of the population, by 2030.

India, which has 61.26 million people diagnosed with type 2 diabetes (8.3 percent of the population), ranks second only to China in total cases and third behind the United States and China in terms of prevalence.

"As their populations grow older, health authorities in China and India are seeing many of the same health problems experienced by their Western counterparts, including type 2 diabetes," said John Damonti, president, Bristol-Myers Squibb Foundation. "What's worse, we are seeing only the tip of the iceberg. For every patient in China or India who has been diagnosed with type 2 diabetes, there are several others who are undiagnosed or considered pre-diabetic. That is why we are working with our prestigious partners in both countries to address this growing public health issue."

***Together on Diabetes* will build upon work the Foundation and its partners in Asia are doing to reduce health disparities in hepatitis B and C by strengthening community-based health care worker capacity and by integrating medical care and community-based supportive services through its *Delivering Hope*™ initiative, which started in 2002.**

China

Recognizing the growing epidemic of type 2 diabetes, the Chinese government set specific goals for the prevention and control of diabetes in its 12th Five-Year Plan, adopted in 2011. The Plan calls for 40 percent of adults with type 2 diabetes to have their glycemic levels under control by 2015, up from 35.5 percent today. Reaching that goal will require communities large and small to more effectively counter the spread of diabetes, especially in rural Western China, where the prevalence rate is greater than in China's cities and where rising medical costs contribute to poverty.

The **Chinese Center for Disease Control and Prevention (China CDC)** will receive $709,016 over three years to enhance the capacity of rural health care providers to manage and prevent type 2 diabetes at the village level in Western China. China CDC's efforts will focus on identifying high-risk rural populations and ensuring timely intervention to prevent the onset of disease. It also will enhance disease awareness and health education by offering standardized training courses for diabetes prevention and control in rural settings and by employing technology to help improve patient self-management.

With a population of more than 23 million, there are nearly 4 million people with diabetes in Shanghai alone. A survey conducted by the Shanghai Center for Disease Control (SCDC) shows the prevalence of type 2 diabetes in the world's most populous municipality reached 16 percent in 2011, more than six percentage points above the national average.

Shanghai Charity Foundation will receive $522,797 over three years to implement a community-based, block-by-block approach for managing type 2 diabetes in Shanghai. Working with the SCDC and the Shanghai Municipal Health Bureau, the Foundation will leverage existing city management systems and technology to build and pilot an integrated model of diabetes prevention and management that can be deployed in other Chinese cities.

A key component of the project is using knowledgeable diabetes patients to share their experiences with other patients and help their peers improve their diabetes self-management skills. Special emphasis will be placed on empowering diabetes patients to prevent and manage diabetic complications.

Bristol-Myers Squibb Foundation

Together ON Diabetes™

Communities Uniting to Meet the Challenge of Diabetes in China and India

India

The prevalence of diabetes in India has grown roughly four-fold since the early 1970s – from about 2 percent of the population in 1972 to 8.3 percent today – due to factors ranging from genetic predisposition to lifestyle and dietary changes. By 2030, 101.2 million people in India – about 1 in 10 – will have type 2 diabetes if current trends persist, the International Diabetes Federation projects.

"Stemming the rising tide of type 2 diabetes in India will require a concerted and sustained effort at the community level to ensure adults have access to the education, preventive measures and care they need to effectively self-manage their disease," Damonti said. "The grants we are making through our *Together on Diabetes* initiative will test new ideas about how diabetes control efforts can be best designed and implemented to help adults in a variety of settings."

Mamta Health Institute for Mother and Child, a national organization based in New Delhi and operating in 14 Indian states, will receive $706,995 over three years for a pilot study to determine the feasibility of involving India's lay community health workers and integrating modern and traditional systems of medicine to prevent and control non-communicable diseases, especially type 2 diabetes.

Community based workers (*Arogya Kiran* – a ray of hope for health) will be trained to provide preventive and promotive care for non-communicable diseases and conditions besides maternal child health services using aspects of both modern and AYUSH medicine. Key self help community groups will be involved including Registered Medical Practitioners and school teachers in order to expand the scope of coverage and utilisation of services.

These specially trained *Arogya Kiran* will reach households with risk management education, family counselling, community mobilization and referral linkages. The project aims to improve lifestyle, early detection and health seeking behaviors.

Gujarat University's **All India Institute of Diabetes and Research** in Naranpura and **Swasthya Diabetes Hospital** in Ahmedabad will receive $465,685 over two years to provide medical education about the diagnosis and management of uncomplicated type 2 diabetes to medical officers working at public and community health clinics. These health care providers also will learn how to screen for diabetes complications. The project plans to train about 80 medical officers and ultimately improve health care quality and outcomes for 40,000 people.

Sanjivani Health and Relief Committee, a Registered Public Trust that provides free medical care to farm laborers and daily wage earners who live below the poverty line in rural Gujarat, will receive $426,374 over four years to conduct a household-by-household study of type 2 diabetes in 348 villages that do not have a hospital, chemist or other medical assistance within five to seven kilometers. The study will help identify people who need diabetes care and ensure early diagnosis of undetected diabetes among those at high risk of developing diabetes. The study also will determine the prevalence of diabetes-related complications among the rural poor. Patients with target organ damage or other complications will be referred to tertiary centers for care.

Humana People to People will receive $355,991 over two years to reduce diabetes-related morbidity and mortality and prevent the onset of type 2 diabetes among those at increased risk for the disease through timely intervention and home-based diabetes care. The project will help improve access to health care by strengthening the existing system of local health workers known as ASHAs and Auxiliary Nurse Midwives.

United Way Mumbai Helpline will receive $205,362 over two years to use community-based lifestyle interventions for the prevention, early detection and management of type 2 diabetes among working adults and municipal and public school workers in Mumbai.

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> **–John Damonti, President**
> Bristol-Myers Squibb Foundation
> Vice President, Corporate Philanthropy, Bristol-Myers Squibb

Applying for Grants

Funding is awarded to nonprofit organizations through invited requests for proposals. Please submit inquiries regarding U.S. grants to **patricia.doykos@bms.com.** Submit inquiries regarding China and India grants to Phangisile Mtshali, **phangisile.mtshali@bms.com.**

Partnership with other funders, corporate social responsibility initiatives, and government programs and agencies

The Bristol-Myers Squibb Foundation and *Together on Diabetes* welcome and seek opportunities to join forces and resources with other foundations and charities, corporate social responsibility initiatives from diverse industries, and government programs and agencies. Please submit partnership inquiries for the U.S. to **patricia.doykos@bms.com** and for China and India to **phangisile.mtshali@bms.com.**

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The mission of the Bristol-Myers Squibb Foundation is to help reduce health disparities by strengthening community-based health care worker capacity, integrating medical care and community-based supportive services, and mobilizing communities in the fight against disease.

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Together we can prevail.®